

# Yes? No? Maybe So ...

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*Have you had your snack? Do you want your milk? Tell me yes or no!*

As adults, we tend to assume that it is easy to answer such questions but the apparent simplicity of *yes/no* questions is deceiving. In order to answer *yes/no* questions appropriately, children must learn to recognize interrogative forms and intonation contours, and to understand that a response is expected. They must understand most of the lexical items in a question and make a choice based on the relationship of the subject to the predicate. To complicate matters further, questions have many and varied functions. For example, the two questions above are similar in that they both request information but one question involves acceptance/rejection (*Do you want milk?*) while the other is a linguistically more complex question involving confirmation/denial (*Have you had your snack?*). Questions can also be used to request behavior, to display or test the knowledge of the hearer, or they may be used rhetorically.

Despite all these complexities, as a Speech-Language Pathologist I have found that families/caregivers tend to use a lot of questions with children who have severe multiple disabilities. I often hear caregivers and parents comment that, *If only \_\_\_ could answer yes and no ... Things would be so much easier. Or, \_\_\_ can answer yes ... Now if we can only teach her to answer no, then her communication would be so much better.*

This may be an unrealistic goal for children with severe multiple disabilities. Normal children have difficulty understanding and responding appropriate to *yes/no* questions before the age of about 30 months. Studies by Fay (1975), Steffensen (1978) and Horgan (1978) show that by the age of about 1 ½ years most children are able to recognize *yes/no* questions and respond to fulfill the pragmatic requirement. However, they often fail to understand the semantic content and thus simply respond affirmatively because this usually matches the expectations of the probing adult.

There are other barriers to the acquisition of competence in answering *yes/no* questions for multiple disabled children. The normal child's introduction to the comprehension of negation typically comes in response to the prohibitive *no* addressed to the child by the parents (Bloom & Lahey, 1978; Pea, 1980). Most children learn to respond to prohibitive *no* in their first year (Spitz, 1957) but one might question how a child with severe physical limitations could be in a position to develop the understanding of *no* in the prohibitive sense. Families/caregivers have reported that they seldom say *no* to their severely disabled charges and indeed there is seldom an obvious need to do so.

Another barrier is that families/caregivers of children with severe multiple disabilities seldom receive any consistent feedback when they ask questions. Parents of non-disabled children are able to adjust their questions to the level of competence of the child (Bloom, Rocissano & Hood, 1976) thereby allowing the child to gradually build on that competence. However, caregivers for disabled children must frequently guess what the child understands because of the physical and other obstacles to the child's reliable responses.

In 1989, two other staff at the Arbutus Society for Children and I decided to investigate how caregivers for children with severe multiple disabilities use *yes/no* questions in routine activities. We attempted to answer the following questions:

1. How much of caregivers' dialogue consists of questions, and what percentage of those questions are *yes/no* questions?
2. What is the difference in frequency of questions between the younger and older age groups?
3. Did caregivers ask *true* questions, in that the adult waited for a response as opposed to using questions rhetorically?

This investigation was conducted with the expectation that answering these questions would enable us to improve the quality of caregiver-child interactions to that opportunities for children with severe multiple disabilities to develop their communicative abilities would be maximized.

Eighteen subjects were selected from among the residents of a long-term residential care facility for children. Nine were within a three to five year old age range and nine were within a fifteen to twenty year age range. All of the subjects were nonverbal. The subjects were observed interacting with adults who were caregivers, teachers and therapists, and video samples were analyzed. A total of forty-one caregivers participated in the research. The subjects and adults were observed together during three different activities: meals, transfers and swimming.

*Question 1: How much of the caregivers' dialogue consists of questions, and what percentage of those questions are yes/no questions?*

We frequently enter into communicative interactions with the intent of creating a dialogue. Questions constitute a portion of this natural dialogue. Holzman (1972) reported 15% - 33% of mother's utterances were composed of interrogatives. However, for caregivers of children with severe multiple disabilities, we suspected they may in fact ask for fewer questions, due to the reduced and limited frequency of response from the children. In fact, the caregivers in this study asked just as many questions as mothers of non-disabled children.

Review of the raw data suggested that questions often appeared in clusters within the dialogue. Frequently, caregivers would ask a question and repeat or rephrase it. Thus, although the frequency of questions in conversation was similar between the caregivers of disabled and mothers of no-disabled (disabled: 25% of total utterances; non-disabled: 15% - 33% of total utterances) the number of *different* questions was less with the disabled children, because there were more repetitions. Of all the questions asked, the *yes/no* questions were by far the most frequent (75% with the younger group and 84% with the older group of disabled children in our study).

Snow (1977) has noted that the main goal in adult-adult conversations is getting one's turn, while the main goal of an adult in an adult-child conversation is getting the child to take his turns. Caregivers may be inadvertently using questions as a method to get children with severe multiple disabilities to take a turn. If the simplest application of pragmatic knowledge is awareness that a question is being asked and that a response is expected, what

better method than questions to solicit a turn from a child. Caregivers then attempt to create a connected series of turns, the child's turn alternating with their own turn in some semblance of meaningful order to create a dialogue. In an effort to create this dialogue, caregivers therefore may take any behaviors from the child and interpret that as the child's turn. This strategy may account for why caregivers keep asking questions.

*Question 2: What is the difference in the frequency of questions between the younger and older age groups?*

Steffenson (1978) noted, in a study of disabled children, that adults tolerate silence or non-response with younger children to a greater extent than with older children. Our assumption was that caregivers of disabled children, too, would be able to accept a longer period of non-response in younger children than with older children with disabilities. We also assumed that caregivers would ask fewer questions of the older group, based on the premise that caregivers would be more comfortable with creating a dialogue with the younger group as opposed to the older group.

This study demonstrated that age and situation were not variables with regards to:

- a) the frequency of questions being asked, nor
- b) the frequency of *yes/no* questions specifically.

Caregivers asked the older group just as many questions, regardless of the situation. One might conclude that the caregivers' innate desire to create a dialogue during interactions is strong, regardless of the age of the child.

*Questions 3: Did caregivers ask true questions, in that they waited for a response as opposed to using questions rhetorically?*

Holzman (1972) suggested that mothers' use of interrogative forms could be classified as follows:

- 1) request for information (*what do you want?*)
- 2) request for behaviour (*can you relax your leg?*)
- 3) questions designed to display or test the knowledge of the hearer (*what's this?*)
- 4) interrogatives wherein the intonation not the actual words indicate a question (*you're done?*), and
- 5) uses of the interrogative form for the purpose other than questioning (*do you want me to stop feeding you?*) – when it is rhetorical).

Results of this study confirmed that caregivers' use of interrogatives could be classified into these same five categories. As well, caregivers' use of *true* questions (where they expected and waited for a response) was only 29% for the younger group and 53% for the older group. One could hypothesize the caregivers do not use questions in a pre-planned manner, often resulting in a high percentage of questions being used for purposes other than sincerely requesting information. In addition, one could speculate that the reason caregivers do not wait for a response as often as they ask questions is because they are aware that children with severe multiple disabilities cannot respond, due to their physical or mental disabilities. Consequently caregivers take the child's turn and then continue the dialogue.

The clinical implications of this study are clear. Caregivers are going to ask questions of children with severe multiple disabilities and a high percentage of these questions are going to be *yes/no* questions. We, as clinicians, need to train caregivers to ask questions in a more pre-planned manner, based on pragmatic function, as opposed to semantic content.

*Caregivers need to be taught that when asking questions of children with severe multiple disabilities, they need to wait for a response more often.* In so doing, caregivers will be inadvertently signaling to the child it's your turn ... in addition to giving the disabled child an opportunity to respond and be an active participant in the dialogue. As a result, caregivers would give the message to the child that what they have to offer is valued and expected.

If caregivers are going to be waiting for a response which they can then interpret as the child's turn, then *caregivers will require education in identifying subtle and discrete responses as opposed to obvious responses.*

*Caregivers need to be aware of their intentions in asking questions.* This will assist them to ask better questions, thereby prompting children with severe multiple disabilities to take more, hopefully better, turns in the dialogue caregivers create with them.

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